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DCFS FATALITY REVIEWS

FY2020

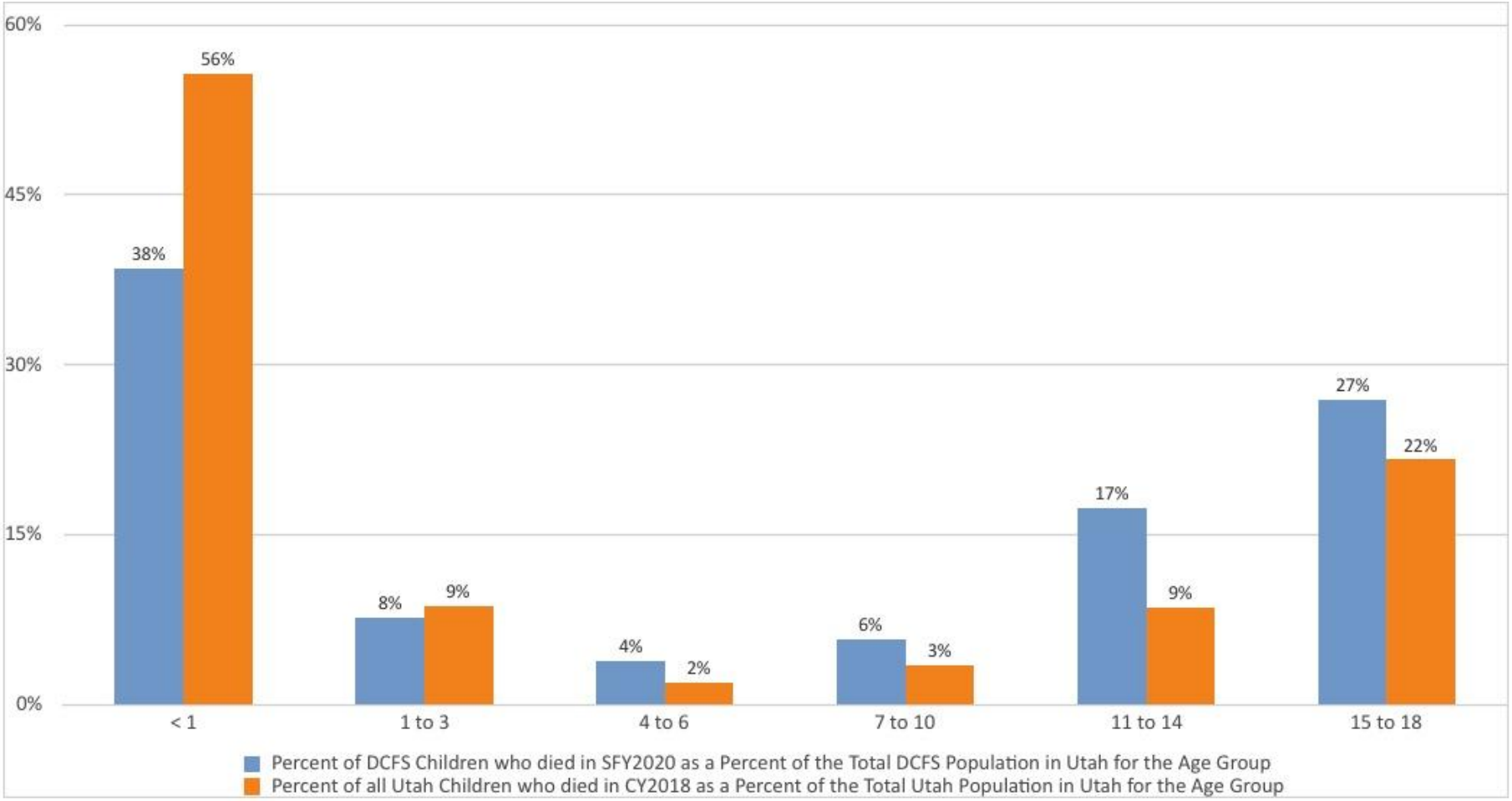
DHS FATALITY REVIEW PROCESS

- Open case with a DHS division up to 12 months preceding the death
- Members include division staff, law enforcement, Safe and Healthy Families, the Children's Justice Center and a suicide prevention expert
- Thoroughly review case logs, law enforcement reports, Medical Examiner and Vital Statistics
- Identify issues in case practice; provide insight into systemic strengths and deficits
- This year, process improvements include continued work with national experts to prioritize system accountability and the identification of suicide risk factors

FY19 DCFS RECOMMENDATION IMPLEMENTATION

- Broadened suicide screening requirements to all children 10 and older, and for use in all program areas
- Created tracking system to ensure suicide screeners are being used consistently and correctly via data reports and hand audits
- Suicide screener surveys sent to caseworkers and supervisors to identify any barriers
- Expanding the practice guideline requirement to assess safe sleep environments for children in-utero to 12 months; continued offering FinnBins when a safe sleeping environment is of concern

Utah Child Fatalities and DCFS Fatalities by Age Group



DCFS Involved and Statewide Youth Suicide Deaths, 10-19 y/o (2015-2020)

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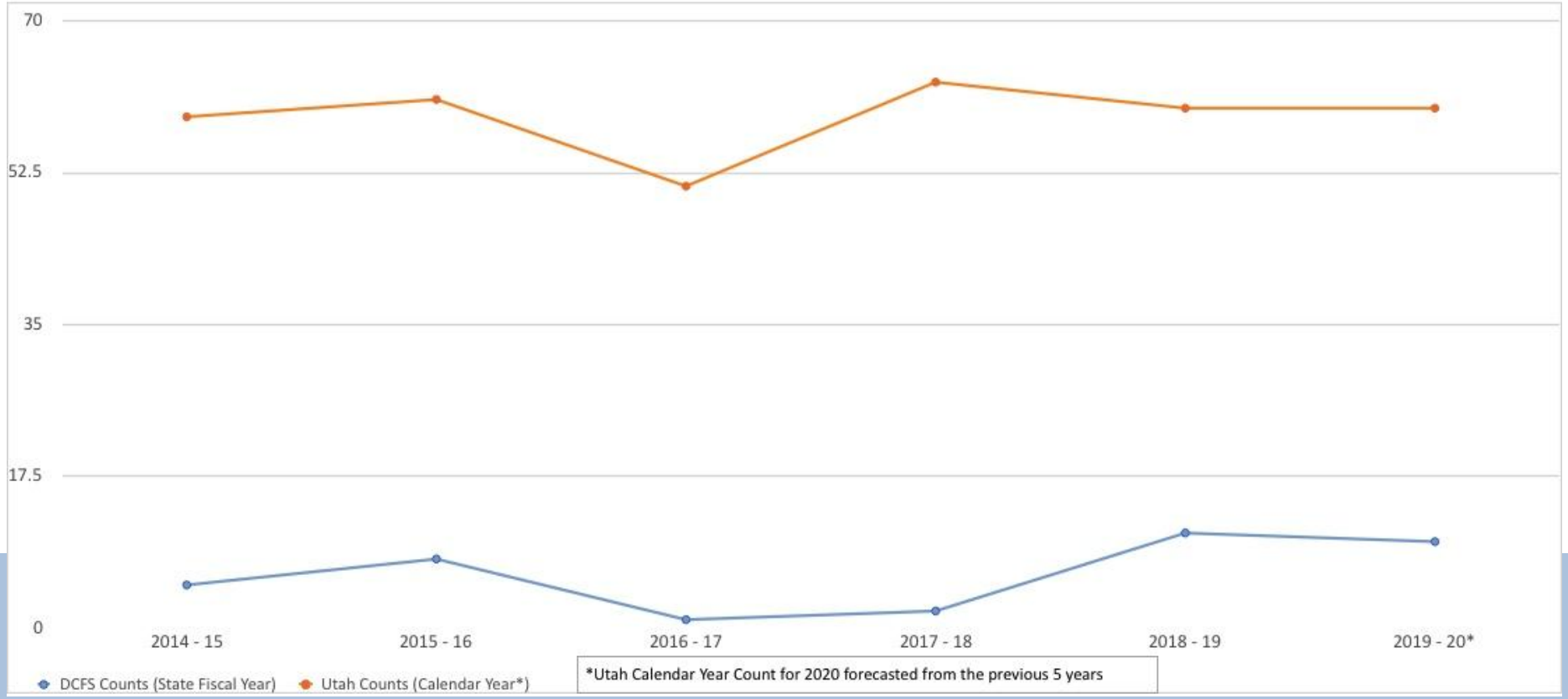

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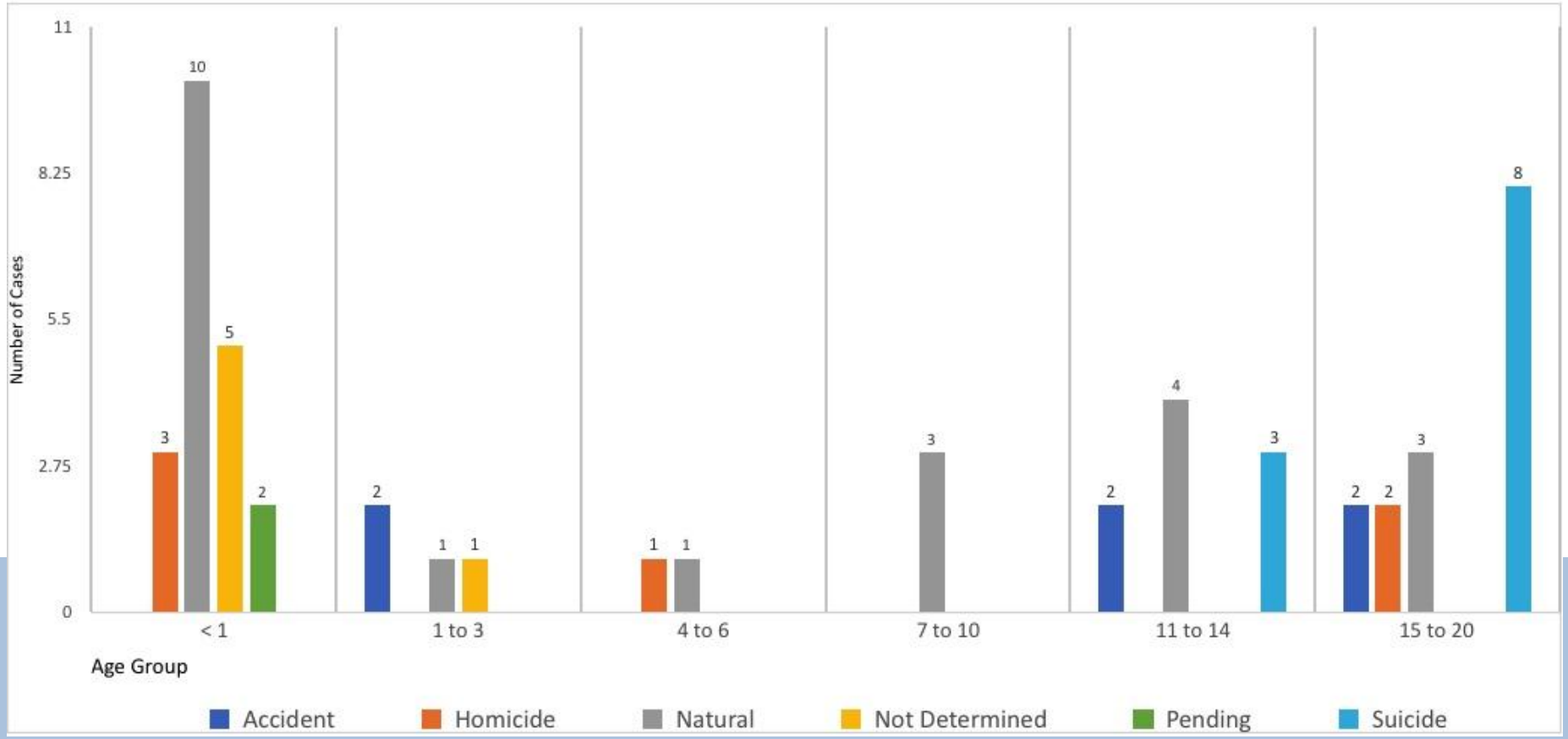
DCFS Reviewed Cases, Medical Examiner Manner of Death by Age Group



SUMMARY OF FY20 RECOMMENDATIONS

- Improving communication between caseworkers and medical providers
- Enhancing safety science and other beneficial formal training to look at system response and improvements
- Increasing the availability of supportive services for caseworkers, specifically language interpreters and refugee services
- Tracking fatalities of children with complex medical needs and fatalities where a caregiver was impaired due to the illegal misuse of substances

QUESTIONS